

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009730

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 217

STATE FILE NUMBER

J. PLACE OF DEATH
a. COUNTY

ST LOUIS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN KOCHLength of stay in 1b
107 daysc. CITY
OR TOWN ST LOUISInside Limits
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION ROBT KOCH HOSPInside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
3761 FINNEYReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

LEE

First

BYRD

Middle

Last

4. DATE
OF DEATH

JAN 18

Day

Year 1963

5. SEX

M

6. COLOR OR RACE
non white7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐8. DATE OF BIRTH
3-21-069. AGE (last birthday)
56IF UNDER 1 YEAR
Months DaysIF UNDER 24 HR
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)
ST LOUIS MO12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME

CRETENER

13b. MOTHER'S MAIDEN NAME

MOLLIE MARY

14. NAME OF HUSBAND OR WIFE

NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)16. SOCIAL SECURITY NO.
493-10-1434

17. INFORMANT

Address

HOSPITAL RECORD - KOCH HOSPITAL

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cor pulmonale & failure

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Far advanced pulmonary tuberculosis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐20a. ACCIDENT ☐SUICIDE ☐HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from OCT 3, 1962 to JAN 18/63 and last saw him alive on JAN 18/63
Death occurred at 6 30 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Frank Cohen

(Degree, title)

22b. ADDRESS

ROBT KOCH HOSP KOCH MO

22c. DATE SIGNED

1-18-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

1-24-63

23c. NAME OF CEMETERY OR CREMATORY

Washington Park Cemetery

23d. LOCATION (City, town, or county)

St. Louis County, Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

G. Wade Granberry

4202 Finney Ave.

25. DATE RECD. BY LOCAL REG.

1-22-63

26. REGISTRAR'S SIGNATURE

J. M. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Avenue
St. Louis 13, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply

with the above constitutes grounds for revocation of license)

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.